CLIENT REGISTRATION FORM

NAME (First/Last): _____ ☐ MALE ☐ FEMALE

DATE OF BIRTH: ____ / ____ / ____ PHONE NUMBER: (____) _____

PHYSICAL ADDRESS: _____ MAILING ADDRESS: (If Different) _____

☐ No Residence/Homeless

EMERGENCY CONTACT INFORMATION *(Attach additional papers if more than one person):*

NAME (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

ETHNICITY

☐ HISPANIC OR LATINO

☐ NON-HISPANIC OR LATINO

RACE

☐ WHITE, CAUCASIAN

☐ HISPANIC

☐ AMERICAN INDIAN / ALASKAN NATIVE

☐ ASIAN

☐ BLACK / AFRICAN AMERICAN

☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

☐ OTHER _____

If you do not speak English, what is your primary language?_____

☐ I was provided the *Notice of Privacy Practices*

YOUR INCOME IS:

(The Service Provider will supply you with the current Federal Poverty Guidelines and 300% SSI amount.)

☐ BELOW POVERTY **OR** ☐ ABOVE POVERTY

☐ BELOW 300% SSI **OR** ☐ ABOVE 300% SSI

DO YOU:

LIVE ALONE? ..... ☐ Yes ☐ No

HAVE A DISABILITY? ..... ☐ Yes ☐ No

CONSIDER YOURSELF FRAIL? ..... ☐ Yes ☐ No

RECEIVE STATE MEDICAID? ..... ☐ Yes ☐ No

ARE YOU:

UNABLE TO LEAVE YOUR HOME WITHOUT ASSISTANCE (Homebound)? ..... ☐ Yes ☐ No

A CAREGIVER?..... ☐ Yes ☐ No

If you are a caregiver, who do you care for?

☐ Spouse ☐ Child, Age 0-18 ☐ Adult Child, 18+

☐ Parent ☐ Family Member ☐ Other _____

Activities of Daily Living (ADLs)

Without assistance, I am unable to:

☐ Bathe ☐ Get Dressed

☐ Eat ☐ Use the Bathroom

☐ Walk ☐ Transfer In or Out of a Bed or Chair

☐ **None – I can perform these activities**

Instrumental Activities of Daily Living (IADLs)

Without assistance, I am unable to:

☐ Prepare Meals ☐ Do Light Housework

☐ Take Medication ☐ Do Heavy Housework

☐ Manage Money ☐ Use the Telephone

☐ Shop ☐ Use Transportation Services

☐ **None – I can perform these activities**

_____ _____ _____ _____

Client Signature *(Initial or Revised Registration)* Date Client Signature – 2nd year (I certify that my information has not changed.) Date

FOR OFFICE USE ONLY

Services Registered For: ***New to This Service?*** ***Nutrition Risk Assessment Score:*** _____

☐ _____ ☐ Y ☐ N ***Site:*** _____

☐ _____ ☐ Y ☐ N ***Notes:*** _____

CLIENT REGISTRATION FORM

NAME (First/Last): _____ ☐ MALE ☐ FEMALE

DATE OF BIRTH: ____/____/____ PHONE NUMBER: (____) _____

PHYSICAL ADDRESS: _____ MAILING ADDRESS: _____
(If Different) _____

☐ No Residence/Homeless

EMERGENCY CONTACT INFORMATION:

NAME 1 (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

NAME 2 (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

ETHNICITY

☐ HISPANIC OR LATINO
☐ NON-HISPANIC OR LATINO

RACE

☐ WHITE, CAUCASIAN
☐ HISPANIC
☐ AMERICAN INDIAN / ALASKAN NATIVE
☐ ASIAN
☐ BLACK / AFRICAN AMERICAN
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ OTHER _____

If you do not speak English, what is your primary language?_____

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YOUR INCOME IS:

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☐ BELOW POVERTY **OR** ☐ ABOVE POVERTY
☐ BELOW 300% SSI **OR** ☐ ABOVE 300% SSI

DO YOU:

LIVE ALONE? ..... ☐ Yes ☐ No
HAVE A DISABILITY? ..... ☐ Yes ☐ No
CONSIDER YOURSELF FRAIL? ..... ☐ Yes ☐ No
RECEIVE STATE MEDICAID? ..... ☐ Yes ☐ No

ARE YOU:

UNABLE TO LEAVE YOUR HOME WITHOUT ASSISTANCE (Homebound)? ..... ☐ Yes ☐ No
A CAREGIVER? ..... ☐ Yes ☐ No

If you are a caregiver, who do you care for?

☐ Spouse ☐ Child, Age 0-18 ☐ Adult Child, 18+
☐ Parent ☐ Family Member ☐ Other _____

_____ _____ _____ _____
Client Signature *(Initial or Revised Registration)* Date Client Signature – 2nd year (I certify that my information has not changed.) Date

FOR OFFICE USE ONLY

Services Registered For: ***New to This Service?***
☐ _____ ☐ Y ☐ N
☐ _____ ☐ Y ☐ N

Nutrition Risk Assessment Score: _____
Client ID: _____
Notes: _____